Committee on Operating Rules For Information Exchange (CORE®)

A CAQH CORE Open Mic Session:
Ask Any Question

November 20, 2012
2:00 pm – 3:00 pm ET

Participating in Today’s Interactive Event

• Download a copy of today’s presentation
• The phones will be muted upon entry and during the speaker portion of the session
• At any time throughout today’s presentation, you may communicate with our panelists via the web
  – Submit questions directly through the Q&A pane located at the bottom right hand corner of your screen
• Panelists will address audience Q&A for approximately 35-40 minutes of today’s session
  – Ask your question by phone at the designated time by pressing * followed by the number one (1) on your keypad
  – Ask your question via the web at any time by entering it into the Q&A pane in the lower right hand corner of your screen
Session Topics

- Welcome and Introductions
- ACA Section 1104: Mandated Operating Rules (20 minutes)
  - Open Mic: Timeline and Compliance questions to CMS OESS
- ACA Mandated Eligibility and Claim Status Infrastructure Operating Rules (15 minutes)
  - FAQs: Real-time Processing Key Rule Requirements
  - Open Mic: Infrastructure Rule Requirements
- ACA Mandated Eligibility & Benefits Data Content Operating Rules (15 minutes)
  - FAQs: Service Type Code Requirements & Patient Financials
  - Open Mic: Eligibility & Benefits Data Content Rule Requirements
- Implementation Resources

Polling Question #1
Readiness for January 2013

Which answer best describes your organization’s progress toward complying with the January 2013 operating rule mandate?

- Conducting planning and requirements analysis
- Systems design and development in process
- Internal systems testing underway
- Trading partner implementation testing underway
- Deployment/rollout with trading partners underway or complete (may include Voluntary CORE Certification)
- Not Applicable (a non-HIPAA covered entity)
ACA Section 1104:  
Mandated Eligibility and Claim Status Operating Rules

Administrative Simplification: ACA Section 1104

- Section 1104 of the ACA (H.R.3590)
  - Establishes new requirements for administrative transactions that will improve the utility of the existing HIPAA transactions and reduce administrative costs*
  - Requires all HIPAA covered entities be compliant with applicable HIPAA standards and associated operating rules
- The first set of mandated operating rules for Eligibility and Claim Status has been adopted into Federal regulation: 42 Days Until Compliance Date
  - December 2011, CMS adopted CMS-0032-IFC as a Final Rule; industry implementation efforts underway for the January 1, 2013 effective date
    - Adopted Phase I and II CAQH CORE Operating Rules for the Eligibility & Claim Status transactions, except for rule requirements pertaining to Acknowledgements*
    - Highlights CORE Certification is voluntary; further defines relationship between standards and operating rules and analysis of ROI from operating rules implementation

The complete set of CAQH CORE Eligibility & Claim Status Operating Rules are available free of charge HERE.

*On September 22, 2011, NCVHS issued a letter recommending Acknowledgements be adopted as formally recognized standards and the CAQH CORE Operating Rules for these standards also be recognized.
ACA Mandated Operating Rules Compliance Dates:
Required for all HIPAA Covered Entities

NOTE: Operating rules apply to HIPAA covered entities; beyond HIPAA compliance penalties, certification penalties for health plans will apply.

Implement by January 1, 2013
Operating Rules for:
• Eligibility for health plan
• Claims status transactions

Implement by January 1, 2014
Operating Rules for:
• Electronic funds transfer (EFT) transactions
• Health care payment and remittance advice (ERA) transactions

Implement by January 1, 2016
Operating Rules for:
• Health claims or equivalent encounter information
• Enrollment and disenrollment in a health plan
• Health plan premium payments
• Referral certification and authorization
• Health claims attachments

ACA Federal Compliance Requirements:
Highlights & Key Dates

Three dates are critical for industry implementation of the first set of ACA mandated Operating Rules
There are two types of penalties related to compliance\(^1\)

<table>
<thead>
<tr>
<th>Key Area</th>
<th>HIPAA Mandated Implementation</th>
<th>ACA-required Health Plan Certification</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Dates</strong></td>
<td>First Date: January 1, 2013</td>
<td>Second Date: December 31, 2013</td>
</tr>
<tr>
<td><strong>Description</strong></td>
<td>Compliance Date</td>
<td>Health Plan Certification Date</td>
</tr>
<tr>
<td>Who: All HIPAA covered entities</td>
<td>Who: Health plans</td>
<td>Who: Health plans</td>
</tr>
<tr>
<td>Action: Implement CAQH CORE Eligibility &amp; Claim Status Operating Rules</td>
<td>Action: File statement with HHS certifying that data and information systems are in compliance with the standards and operating rules(^2)</td>
<td>Action: HHS will assess penalties against health plans that have failed to meet the ACA compliance requirements for certification and documentation(^2)</td>
</tr>
<tr>
<td><strong>Applicable Penalties</strong></td>
<td>Amount: Due to HITECH, penalties for HIPAA non-compliance have increased, now up to $1.5 million per entity per year</td>
<td>Amount: Fee amount equals $1 per covered life(^3) until certification is complete; penalties for failure to comply cannot exceed an annual basis an amount equal to $20 per covered life or $40 per covered life for deliberate misrepresentation</td>
</tr>
</tbody>
</table>

---

\(^1\) CMS OESS is the authority on the HIPAA and ACA Administrative Simplification provisions and requirements for compliance and enforcement. The CMS website provides information on the ACA compliance, certification, and penalties and enforcement process.

\(^2\) According to CMS, regulation detailing the health plan certification process is under development, and they will release details surrounding this process later this year. CAQH CORE will continue to offer its voluntary CORE Certification program and will share lessons learned with CMS as the Federal process is developed.

\(^3\) Covered life for which the plan’s data systems are not in compliance, shall be imposed for each day the plan is not in compliance.
Q&A with CMS OESS
ACA Section 1104 Compliance Requirements

Please submit your question:
• By Phone: Press * followed by the number one (1) on your keypad
• Via the Web: Enter your question into the Q&A pane in the lower right hand corner of your screen

CAQH CORE Eligibility & Claim Status
Infrastructure Operating Rules
Applying CAQH CORE Operating Rules

- Healthcare operating rules pair data content and infrastructure operating rules to help data flow consistently in *varied settings and with various vendors*

<table>
<thead>
<tr>
<th>Type of Rule</th>
<th>Addresses</th>
<th>CAQH CORE Eligibility &amp; Claim Status Operating Rules</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Data Content:</strong> Eligibility</td>
<td>Transaction Value</td>
<td>More Robust Eligibility Verification Plus Financials</td>
</tr>
<tr>
<td><strong>Infrastructure:</strong> Eligibility and Claim Status</td>
<td>Common/accessible documentation</td>
<td>Enhanced Error Reporting and Patient Identification</td>
</tr>
</tbody>
</table>
| | Architecture/performance/connectivity | "We are addressing the important role acknowledgements play in EDI by strongly encouraging the industry to implement the acknowledgement requirements in the CAQH CORE rules we are adopting herein."
| | Response Times | HHS Interim Final Rule |
| | Connectivity and Security | |
| | Acknowledgements* | |

*Please Note: In the Final Rule for Administrative Simplification: Adoption of Operating Rules for Eligibility for a Health Plan and Health Care Claim Status Transaction, CORE 150 and CORE 151 are not included for adoption. HHS is not requiring compliance with any operating rules related to acknowledgement, the Interim Final Rule.*
FAQs: Infrastructure Operating Rules

Response Time Requirements

- When processing in real time, maximum response time for receipt of a v5010 X12 271 or X12 276 by the provider in response to a v5010 X12 270 or X12 276 must be 20 seconds
- To conform to response time requirement, 90 percent of all transactions, as measured within a calendar month, must be returned within the 20-second maximum response time

NOTE: The rules hold the health plan and its contracted business associates responsible for the conduct of the transaction that is applicable to them.

CAQH CORE Rules 156 & 250

When Do the 20-Seconds Begin and End?

The 20-second requirement is the duration for the entire round trip of the transaction

- The 20 seconds begin when the v5010 X12 270 Inquiry or X12 276 Request is first submitted by the provider, and end when the X12 271 or X12 277 Response is received by the provider
- All ensuing hops between the provider and the health plan are included in these 20 seconds

- ACA Administrative Simplification provisions require all HIPAA covered entities (i.e., health plans, providers, clearinghouses, etc.) to comply with the Federally mandated CAQH CORE Eligibility & Claim Status Operating Rules
- Each HIPAA covered entity within the transaction flow is bound by the CAQH CORE requirements for meeting the 20-second round trip of the transaction
- CAQH CORE recommends a maximum of 4 seconds per hop to meet the 20-second round trip requirement

CAQH CORE Real Time Processing: Potential Real Time Transaction Paths

End-to-End: 20-Second Round Trip
(CAQH CORE recommends no more than 4 seconds per hop)

Path #1: Direct Connection: A+B= 20 seconds or less
Path #2: Single Clearinghouse: A+B+C+D= 20 seconds or less
Path #3: Dual Clearinghouse: A+B+C+D+E+F = 20 seconds or less

Healthcare Provider
Health Plan

At starred receipt and transmit points each entity must capture, log, audit, match, & report date, time, and control numbers from its own internal systems and corresponding data received from its trading partners.
FAQs: Infrastructure Operating Rules
Logging and Auditing Requirements

• **Question:** How Should The X12 270/271 and X12 276/277 transactions be tracked throughout a system/application to demonstrate conformance with the response time requirements specified In CAQH CORE Rules 155 and 250?

• **Answer:**
  – The CAQH CORE Response Time Rules require HIPAA covered entities to capture, log, audit, match, and report the date, time, and control numbers from their own internal systems, and corresponding data received from their trading partners. The auditing requirement is included so that each entity will have the log of data to be used to resolve any issues or concerns. For the 20-second maximum real time response requirement, this log could also be used to identify where a bottleneck may be occurring.
  – Section 4.3.4 of the CAQH CORE 270: Connectivity Rule also specifies that, to comply with CAQH CORE Rules 155 and 156 message receivers will be required to track the times of any received inbound messages, and respond with the outbound message for that payload ID. Additionally, message senders must include the CORE Envelope Metadata element Time Stamp (as specified in CAQH CORE Rule 270 Section 4.1.2). Other data may be required for auditing purposes; however, this data can be determined by each entity.
  – CAQH CORE recommends that, in order to uniquely identify an X12 transmission, entities store the ISA06, ISA08, ISA13, GS02, GS03, GS06, ST02, TRN02, and if sent in the transaction, the BHT03.
  – The audit log requirement was purposefully specified at a high level in each rule to enable each entity along the transaction pathway to design and develop its own process for audit handling. Additionally, the rules do not specify how long an entity is to maintain the data for auditing purposes.

Q&A with CAQH CORE
CAQH CORE Eligibility & Claim Status
Infrastructure Rule Requirements

Please submit your question:
• **By Phone:** Press * followed by the number one (1) on your keypad
• **Via the Web:** Enter your question into the Q&A pane in the lower right hand corner of your screen
CAQH CORE Eligibility & Claim Status

Data Content Operating Rules

The Foundation of CAQH CORE Operating Rules
Related to Data Content: v5010 ASC X12 Standards

Building a consistent infrastructure for the delivery of robust patient eligibility and benefit data
Applying CAQH CORE Operating Rules

- Healthcare operating rules pair data content and infrastructure operating rules to help data flow consistently in varied settings and with various vendors.

<table>
<thead>
<tr>
<th>Type of Rule</th>
<th>Addresses</th>
<th>CAQH CORE Eligibility &amp; Claim Status Operating Rules</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Data Content: Eligibility</strong></td>
<td>Transaction Value</td>
<td>More Robust Eligibility Verification Plus Financials</td>
</tr>
<tr>
<td><strong>Infrastructure: Eligibility and Claim Status</strong></td>
<td>Common/accessible documentation</td>
<td>Companion Guides</td>
</tr>
<tr>
<td></td>
<td>Architecture/performance/connectivity</td>
<td>Response Times</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

*Please Note: In the Final Rule for Administrative Simplification: Adoption of Operating Rules for Eligibility for a Health Plan and Health Care Claim Status Transaction, CORE 150 and CORE 151 are not included for adoption. HHS is not requiring compliance with any operating rules related to acknowledgment, the Interim Final Rule.

---

CAQH CORE Eligibility & Claim Status

Key Requirements: **Data Content Operating Rules**

- An ASC X12 271 eligibility response to a generic & explicit ASC X12 270 eligibility request must include health plan name and patient financials for co-insurance, co-payment, base & remaining deductibles (with network variance if applicable), e.g.,
  - Must return CORE-required data for explicit inquiry requests including one of 51 total CORE-required Service Type Codes (STCs):

<table>
<thead>
<tr>
<th>Service Type Code</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>81 – Medical Care</td>
<td>Medical Care</td>
</tr>
<tr>
<td>82 – Oral Surgery</td>
<td>Oral Surgery</td>
</tr>
<tr>
<td>83 – Home Health Care</td>
<td>Home Health Care</td>
</tr>
<tr>
<td>84 – Dental Care</td>
<td>Dental Care</td>
</tr>
<tr>
<td>85 – Hospice</td>
<td>Hospice</td>
</tr>
<tr>
<td>86 – Emergency Services</td>
<td>Emergency Services</td>
</tr>
<tr>
<td>87 – Hospital</td>
<td>Hospital</td>
</tr>
<tr>
<td>88 – Pharmacy</td>
<td>Pharmacy</td>
</tr>
</tbody>
</table>

- Health plan must normalize submitted and stored last names; if normalized name is not validated, must return a specified AAA code.
- Health plans must return specified AAA Error Codes with submitted patient identifying data elements to communicate certain error conditions.
FAQs: Data Content Operating Rules

Patient Financial Responsibility Requirements

• **Question:** How should my health plan conform to the CAQH CORE Rule 260 Section 4.1.3 requirements for plans to return patient financial responsibility for base and remaining deductible (health plan and benefit-specific), co-insurance, and co-payment if the plan does not include patient financials?

• **Answer:**
  - As the CAQH CORE rules require the return of specific patient financial data, including co-payment, co-insurance, base and remaining deductible, etc., if the benefit plan for the member does not have these patient financials, the health plan would return a “0” (zero) in the required financial fields
    - E.g. the health plan would be required to return Health Plan Base Deductible (0), Health Plan Remaining Deductible (0), Benefit Specific Co-Pay (0), and Benefit Specific Co-Insurance (0)
  - The ASC X12N v5010 270/271 Technical Report Type 3 (TR3) specifies what data should be returned when a patient has no financial responsibility for a benefit/service type

FAQs: Data Content Operating Rules

Service Type Codes (STCs)

• **Question:** Does CAQH CORE provide guidance on how to map our internal benefit codes to the Service Type Codes? Is it possible to get additional clarity on the Service Type Code definition to better understand what services should be provided?

• **Answer:**
  - CAQH CORE does not provide guidance on how a health plan may map its internal codes to the STC codes. This is an implementation decision made by each health plan.
  - For the v5010 X12 270/271 transactions the Service Type Codes (STCs) and corresponding definitions are specified in the v5010 X12 270/271 Technical Report Type 3 (TR3). CAQH CORE does not redefine the STCs. However, for some codes CAQH CORE has included “supplemental descriptions” in CAQH CORE Rule 260. These definitions are for guidance only to aid in a common industry understanding as noted in Footnote #2 in Table 4.1.1.1. Information related to the meaning, use, and interpretation of ASC X12 Standards, Guidelines, and Technical Reports, including implementation guidance for the ASC X12N v5010 270/271 can be obtained from ASC X12 via its online ASC X12 Interpretation Portal.
Q&A with CAQH CORE
CAQH CORE Eligibility & Claim Status
Data Content Rule Requirements

Please submit your question:
• By Phone: Press * followed by the number one (1) on your keypad
• Via the Web: Enter your question into the Q&A pane in the lower right hand corner of your screen

Examples: CAQH CORE Implementation Tools

• Trading Partner Testing Readiness Site: Which organizations are ready to test their implementation of operating rules with trading partners?
  – If you are ready to do testing with your trading partners – add the name of your organization today…adding your name takes less than five minutes!

• FAQs: CAQH CORE has a list of FAQs to address typical questions regarding the operating rules; updated FAQs being loaded to website as appropriate given mandates

• Request Process: After reviewing FAQs, contact experts as needed at CORE@caqh.org

• Voluntary CORE Certification: Phase I & Phase II CORE Certification Master Test Suites provide guidance on the stakeholder types to which the rules apply and working with trading partners; enables conformance testing for implementers
Examples: CMS OESS Implementation Tools

- **HIPAA Covered Entity Charts**
  - Determine whether your organization is a HIPAA covered entity
- **CMS FAQs**
  - Frequently asked questions about the ACA, operating rules, and other topics
- **Affordable Care Act Updates**
  - Updates on operating rules; compliance, certification, and penalties; and engagement with standards and operating rules
- **Additional Questions**
  - Questions regarding HIPAA and ACA compliance can be addressed to:
    - Chris Stahlecker, OEM/OESS/ASG Acting Director, Administrative Simplification Group, Christine.Stahlecker@cms.hhs.gov
    - Geanelle Herring, Health Insurance Specialist, Geanelle.Herring@cms.hhs.gov

CAQH CORE Upcoming Education Programs

- View the upcoming *Free CAQH CORE Education Events*
  - Standards and Operating Rules Working in Unison
    - CAQH CORE and ASC X12 "Implementing ACA Mandated Operating Rules Related to Eligibility Data Content", Wednesday, November 28, 2012 | 2:00pm – 3:30pm ET
    - CAQH CORE and NACHA "Alignment of Financial Services and Healthcare: The EFT Standard and Operating Rules for EFT & ERA", Thursday, November 29, 2012 | 2:00pm ET - 3:00pm ET
  - CAQH CORE Town Hall Call – December 11, 2012
  - Other joint CAQH CORE Education Sessions
    - InstaMed, "Working with Trading Partners", Tuesday, December 4, 2012 | 2:00pm – 3:00pm ET
    - WEDI, Wednesday, December 12, 2012 | 2:00pm - 3:30pm ET
    - NeHC, Tuesday, December 18, 2012 | 3:00pm - 4:30pm ET
Thank You for Joining Us

Mandated Eligibility & Claim Status Operating Rules

CAQH CORE Eligibility & Claim Status Operating Rules were initially developed in two phases; for ease of use the rules are presented here by transaction addressed and rule type rather than by phase.

• Rules Addressing the ASC X12 270/271 Eligibility & Benefits Transactions
  – Data Content Related Rules
    • CAQH CORE 154 & 260: Eligibility & Benefits Data Content Rules
    • CAQH CORE 254: Normalizing Patient Last Name Rule for Eligibility
    • CAQH CORE 259: AAA Error Code Rule for Eligibility
  – Infrastructure Related Rules
    • CAQH CORE 150: Batch Acknowledgements Rule for Eligibility (999)*
    • CAQH CORE 151: Real Time Acknowledgements Rule for Eligibility (999)*
    • CAQH CORE 152: Companion Guide Rule
    • CAQH CORE 155: Batch Response Time Rule for Eligibility
    • CAQH CORE 156: Real Time Response Rule for Eligibility
    • CAQH CORE 157: System Availability Rule
    • CAQH CORE 153 & CAQH CORE 270: Connectivity Rules

• Rules Addressing the ASC X12 276/277 Claim Status Transactions
  • CAQH CORE 250: 276/277 Claim Status Infrastructure Rule*

*NOTE: In the Final Rule for Administrative Simplification: Adoption of Operating Rules for Eligibility for a Health Plan and Health Care Claim Status Transactions, requirements pertaining to use of Acknowledgements are NOT included for adoption. Although HHS is not requiring compliance with any operating rule requirements related to Acknowledgements, the Final Rule does note “we are addressing the important role acknowledgements play in EDI by strongly encouraging the industry to implement the acknowledgement requirements in the CAQH CORE rules we are adopting herein.”